Handbook for Providers of Chiropractic Services

Chapter B-200 Policy and Procedures for Chiropractic Services

Illinois Department of Public Aid

CHAPTER B-200

CHIROPRACTIC SERVICES

TABLE OF CONTENTS

APPENDICES

FOREWORD

PURPOSE

This handbook has been prepared for the information and guidance of providers who provide chiropractic services for participants in the Department's Medical Programs. It also provides information on the Department's requirements for provider participation and enrollment.

This handbook can be viewed on the Department's website at

http://www.state.il.us/dpa/handbooks.htm

This handbook provides information regarding specific policies and procedures relating to chiropractic services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's website at

http://www.state.il.us/dpa/medical_programs.htm

Providers will be held responsible for compliance with all policy and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 217-782-5565.

CHAPTER B-200

CHIROPRACTIC SERVICES

B-200 BASIC PROVISIONS

For consideration to be given by the Department for payment of chiropractic services, such services must be provided by a provider enrolled for participation in the Department's Medical Programs. Services provided must be in full compliance with both the general provisions contained in the Handbook for Providers of Medical Services, General Policy and Procedures (Chapter 100) and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

B-201 PROVIDER PARTICIPATION

B-201.1 PARTICIPATION REQUIREMENTS

A provider who holds a valid Illinois (or state of practice) license to practice chiropractic is eligible to be considered for enrollment to participate in the Department's Medical Programs.

The provider must be enrolled for the specific category of service for which charges are to be made, i.e. category 05 - Chiropractic Services.

PROCEDURE: To enroll the provider must complete and submit:

- Form DPA 2243 (Provider Enrollment/Application)
- Form DPA 1413 (Agreement for Participation)
- HCFA 1513 (Disclosure of ownership and controlling interest)
- W9 Request for Taxpayer Identification Number
- Form DPA 2307 Hospital, Professional School or Group Practice as Alternate Payee (if applicable)

These forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment should be addressed to:

PPU@mail.idpa.state.il.us

Providers may also call the unit at (217) 782-0538 or mail a request to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Using DPA Form DPA 2307, an alternate payee may be designated to address the chiropractor's circumstances, which must meet one of the following conditions:

- The provider has a contractual/salary arrangement, as a condition of employment, with a hospital or professional school.
- The provider is part of a practitioner-owned group practice consisting of three or more full-time licensed practitioners or the equivalent thereof.
- The provider is employed by a practitioner who requires, as a condition of employment, that the fees be remitted to the employer.

The forms must be completed (**printed** in ink or typewritten), signed and dated in ink by the provider, and returned to the address on the previous page. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a different enrollment date and it is approved by the Department.

B-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, refer to Appendix B-3.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department's files. If any of the information is incorrect, refer to Topic B-201.4.

B-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten calendar days after this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

B-201.4 PROVIDER FILE MAINTENANCE

The information carried in Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the files updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains

information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Any time a provider effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of a change.

PROCEDURE: The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is any change in a provider's enrollment status or any changes submitted by the provider, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date. The updated sheet will be sent to the provider and to any payee listed if the address is different from the provider.

B-202 CHIROPRACTOR REIMBURSEMENT

When billing for services the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided. Any payment received from a third-party payer, a program participant or other persons incident to provision of chiropractic services, must be reflected as a credit on any claim submitted to the Department bearing charges for covered services. Exception: Department co-payments are not to be reflected on the claim. Refer to Chapter 100, Topic 114 for information regarding patient cost-sharing.

B-202.1 CHARGES

Providers are to make charges to the Department only after services have been provided. Charges made are to be the chiropractor's usual and customary charges as made to the general public for the same service. A provider must charge only for services he or she personally provides. A provider must not charge for services provided by another provider even though one may be in the employ of the other.

B-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Topic 112.3.

Providers billing electronically should take special note of the requirement that Form 194-M-C, Billing Certification Form, must be signed and retained for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies, or other adverse actions. Form DPA 194-M-C can be found on the last page of each Remittance Advice which reports the disposition of any electronic claim. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, the provider should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for the provider to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

B-202.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services provided and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. For specific instructions for preparing claims for Medicare covered services, refer to Appendix B -2.

Form DPA 1443, Provider Invoice, is to be used to submit charges for all chiropractic services provided other than Medicare covered services. A copy of the Form DPA 1443 and detailed instructions for completion are included in Appendices B -1 and B -1a.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix B-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scannability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Illinois Department of Public Aid
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62673-0001
Attention: Vendor/Scanner Liaison

B-202.31 Claims Submittal

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, Form DPA 1444. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim, use Form DPA 1414. A non-routine claim is:

- Any claim to which Form DPA 1411, Temporary MediPlan Card, is attached.
- Any claim to which any other essential document is attached.

For electronic claims submittal, Refer to Topic B-202.2 above. Non-routine claims may not be electronically submitted.

B-202.32 Required Coding - Procedure and Diagnosis Codes

Procedure Codes

All services for which charges are made are to be coded on Form DPA1443, Provider Invoice, with specific codes as described on the Department's fee schedule for chiropractors. Refer to Topic B-202.5. No other procedure codes are acceptable.

Diagnosis Codes

In addition to the coding required which describes the specific procedure performed, all invoices require a primary diagnosis code as listed in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Additionally, chiropractors must identify and code any secondary diagnosis.

B-202.4 PAYMENT

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department. Refer to Chapter 100, Topic 130 and 132, for payment procedures utilized by the Department and General Appendix 8 for explanations of Remittance Advice detail provided to the providers.

B-202.5 FEE SCHEDULE

The Department's maximum reimbursement rates for the allowable procedures are listed on the Department's website. The listing can be found at

http://www.state.il.us/dpa/html/medicaidreimbursement.htm

Paper copies of the listings can be obtained by sending a written request to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
201 South Grand Avenue East
Springfield, IL 62763-0001

The maximum rates, quantity limitation, and prior approval requirements for each service are also available electronically. The Department maintains a downloadable rate file suitable for use in updating a provider's computerized billing system. This file is located in the same area on the Department's website as the listings described above. A copy of this file can also be obtained by sending a blank 3.5 inch IBM PC compatible diskette, a written request and a self-addressed, prepaid diskette mailer to the address listed above.

Providers will be advised of major changes via a written notice. Provider notices will not be mailed for minor updates such as error corrections or the addition of newly created HCPCS codes.

B-203 COVERED SERVICES

A covered service is a service for which payment can be made by the Department.

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

The services covered in the chiropractic program are limited to the treatment of the spine by manual manipulation to correct a subluxation. Only the following procedures may be submitted for reimbursement by the chiropractor:

- Chiropractic Manipulative Treatment (CMT): Spinal one or two regions
- Chiropractic Manipulative Treatment (CMT): Spinal three or four regions
- Chiropractic Manipulative Treatment (CMT): Spinal five regions
- Chiropractic Manipulative Treatment (CMT): Extraspinal, one or more regions

For each date of service no more than one procedure code may be billed.

B-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered in the Department's Medical Programs. Refer to Chapter 100, Topic 104, for a general list of non-covered services. Additionally, payment cannot be made to chiropractors for these services:

- Services provided to participants eligible for Medicare benefits if the services are determined not medically necessary by Medicare.

- Services provided to participants in group care facilities by a provider who derives direct or indirect profit from total or partial ownership of such facility.

- Office visits - Diagnostic or screening

- Treatment when a definitive pathology is not present.

The Department will not make payments to a provider for x-ray examinations or laboratory tests. A provider may, within his professional prerogative defined by state licensure laws, order x-rays or laboratory tests necessary for diagnosis and treatment of a patient's condition from other qualified providers. Payment for such services will be made directly to those providers if they are participating in the Medical Assistance Program.

B-205 RECORD REQUIREMENTS

The Department regards the maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are a key document for post payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

> In the absence of proper and complete medical records , no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

Providers must maintain an office record for each patient. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the provider rendering the services.

The record maintained by the provider is to include the essential details of the patient's condition and of each service provided. All entries must include the date and must be legible and in English. Records which are unsuitable because of illegibility or because they are written in a language other than English may result in sanctions if an audit is conducted.

For patients who are in a long term care facility, the primary medical record indicating the patient's condition, treatment and services ordered and provided during the period of institutionalization may be maintained as a part of the facility chart; however, an abstract of the facility record, including diagnosis, treatment program, dates and times services were provided, is to be maintained by the provider as an office record to show continuity of care.

B-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED SERVICES

B-210.1 Division of Specialized Care for Children (DSCC)

Federal regulations require that persons less than 21 years of age who have congenital or acquired crippling conditions or conditions leading to crippling must be referred to the Division of Specialized Care for Children (DSCC) for evaluation.

A crippling condition in this context is a tissue or functional defect of bone, muscle and joint origin which is chronic or if unattended, may lead to chronicity with subsequent disability and handicap. Persons in this age group with congenital or acquired systemic disease which may also involve the spine, or conditions which are associated with, or may lead to impairment of the musculo-skeletal system, and those who require specialized health providers for proper evaluation, treatment design and management are to be referred to DSCC.

Conditions which require referral to DSCC include severe or complex handicaps involving the spine which may be crippling or lead to crippling.

B-210.2 Home and Long Term Care Facility Services

A provider may provide services to a participant in his or her place of residence (private home or a long term care facility) when the participant is physically unable to go to the chiropractor's office.

All services provided by the provider to patients in long term care facilities are to be documented by the provider in the medical record which is maintained by the facility, and all orders given by the provider, to be carried out by the facility staff, are to be signed by him or her. A rubber stamp of the chiropractor's signature is not considered adequate. Refer to Topic B-205 for additional record requirements.